



Should doctors charge doctors for their medical services?

Should a medical doctor bill a colleague for the medical services they have provided for them? This question assumes current relevance and importance as most doctors now carry medical aid, which should cover cost, and their collegial service deliverer would not be out of pocket after providing medical attention for them. Also, may the gracious collegial waiver of the past not be rather atrophied, and out of place in the world of today? A salutary certainty is that all doctors will sooner or later seek the advice and services of a colleague. Perhaps it would be timely to reappraise the subject, and attempt to provide guidance for them.

There appears to be no historical guideline in the medical profession for the waiving of fees within it. In an early version (of many) of the Oath, Hippocrates referred to teachers and their families, 'To consider dear to me as my parents him who taught me this art; ... without fee or written promise ...', although the text was possibly referring to the act of teaching rather than the provision of medical care.¹ A previous generation, and many before it, declined to charge colleagues, and even generously extended this waiver to their families. In Britain the practice of yesteryear was to submit an account 'For services rendered – one guinea'. We are told that a previous generation even frowned upon charging ministers of religion, and sometimes teachers. In South Africa it was customary to make a donation to the SAMA Benevolent Fund, in lieu of services rendered, and this was recorded as 'For services rendered to Dr A Jones by Dr B Louw', and the amount donated was recorded. The Chairman of the SAMA Benevolent Fund has recently warned, however, that this laudable practice has declined, and the long-term survival of the Fund is threatened.²

The medical profession has always been enthusiastic about writing guidelines and extensive opinions on all aspects of its endeavours, so what are the given guidelines in the matter of billing colleagues? We have sought and found little written guidance – a virtual vacuum – in South Africa, and in Britain for that matter. Medical texts, including our own, concerning ethics, medicine and the law in South Africa are silent on the subject,^{3,4} as are texts on British medical jurisprudence, taking as an example a major reference work.⁵ The websites of the Health Professions Council of South Africa⁶ and the South African Medical Association⁷ are also silent. The ethical rules of conduct issued by the Department of Health do not address the issue.⁸ The British Medical Association also provides no guidelines.⁹ We did, however, find a judgement by the South African Medical and Dental Council (the predecessor of the Health Professions Council of South Africa) on the question of *entitlement* of medical practitioners to the waiver of fees: 'It

was resolved that no practitioner was entitled to be treated free of charge', was the response, in 1960, to a query by a group of partners who enquired whether it would be ethically correct if they charged one another.¹⁰ The entire matter would therefore appear to be one of etiquette, collegiality and habit, rather than of recommendation, guideline or law. There would appear to be no written curriculum.

Many regard the waiving of fees to be an admirable aspect of medical behaviour, and a matter of good manners in a very old profession. Similar spirits further argue that it would be a commendable thing to do, adding some probity to an already beleaguered discipline. That a doctor should choose a particular colleague to care for them, and not anyone else, is personally flattering. Perhaps, also, the fortunate doctor-patient who has their fees waived might sing the praises of their generous physician, and perhaps even refer, and have others refer, patients to them. In the past, a token gift, usually of a liquid nature, served as an indication of their gratitude.

There are, however, equally strong arguments against this approach. The first to be considered is the time consumed attending to colleagues. There was a senior, much admired obstetrician who was called upon to deliver most of the infants born to the medical profession in his vicinity; this kept him busy most of the day, and literally the night. It severely curtailed the time he could devote to his conventional practice. There is also the danger of becoming a medical albatross, with chronic illness resulting in multiple *pro bono* visits. Not only this, but there may be a multiplier effect, with the colleague's family also seeking attention. To take it to an arguable extreme: should the colleague's receptionist also have a free consultation? This extended favouritism could result in great awkwardness for both parties.

Another argument against the waiving of fees is that most, if not all, doctors are on some form of medical aid anyway. The question of medical aid has two complexities in our context: the first is whether the medical aid is confined to 'in-hospital' activity only (and not attention and procedures performed in a consulting room), and the second is the scale chosen to be charged. Of the first, many, perhaps most, doctors choose a variant of medical aid which only covers 'in-hospital' activity. Such cover is cheaper than the more comprehensive medical aid, and would cover the doctor for a major medical illness in hospital. The problem here is that there is no cover for the common consultations of, say, a general practitioner or dermatologist. The second complexity relates to the price list that is going to be used for the tariff. Tariffs and price lists are a complex and moving terrain, at this time accompanied by



controversy and subject to change. We do not wish to enter into this particular debate in this matter of colleagues billing colleagues.

So should colleagues bill colleagues for personal services rendered? There is no law, regulation or guideline to assist in providing a firm answer to the question. It is therefore a matter between the two parties, which should be agreed by them before the service is rendered. We offer a number of alternatives: A collegial guideline and compromise may be that neither party should be out of pocket, or as little out of pocket as possible, after any interaction. It might be collegial to bill them that which the medical aid will refund them, so that they would not have to 'top up' the bill. If the doctor/patient is not covered by medical aid, or has a type that does not cover out-of-hospital consultation, it might be a graceful gesture for the service provider to waive the charges for their skills and opinion, but bill for all disposables, investigations and other similar items. A donation in lieu of services to the SAMA Benevolent Fund would be an admirable act. It could also be pragmatically argued that the money saved by having 'in-hospital' medical aid might just as well be used to pay the occasional out-of-hospital consultation in an act of levelling the medical and lay playing fields. Finally, while we understand that the form is to absolutely refuse gifts within the profession,

we respectfully suggest that if proffered and pressed – in these circumstances – it might be churlish to decline them.

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